

Program Eligibility Screening Tool

NJ FamilyCare Community Based Palliative Care

Palliative care is extra support for people with serious illnesses. It helps manage symptoms, reduce stress, and works with other treatments. A care team listens to what matters to the member and supports their choices—so they can focus on quality of life. Use this screening tool to determine whether the benefit may be right for the member/patient or for you.

Purpose of the Screening Tool

This referral form is designed to help identify and enroll eligible members into the NJ FamilyCare Community Based Palliative Care benefit. The benefit supports members living with complex or serious illness by addressing medical, psychosocial, and quality-of-life needs.

Who Should Complete This Form?

The Program Eligibility Screening Tool can be completed by a member or by anyone in the community—clinicians or non-clinicians (e.g., family members, caregivers, community organizations, or providers)

Instructions: Step-by-Step

1. REFERRAL INFORMATION SECTION

- Complete your name, credentials, title, and the name and contact information of any additional referring contact.
- Complete the Expected Discharge Date if applicable.
- Provide a reliable phone number and email for follow-up.
- Clearly indicate the recommended palliative care provider provider(s), if known.

2. MEMBER DEMOGRAPHICS

- Complete all fields for the member, including subscriber ID, name, date of birth, address, and contact numbers.
- Indicate the member’s preferred language and fluency levels for both the member and their caregiver/family member.
- Note whether the member has provided consent for referral. Indicate if there is a Healthcare Power of Attorney (POA) or medical decision maker, and if so, provide their contact information.
- Include any relevant caregiver or alternate contact information.

3. PRIMARY CARE PHYSICIAN INFORMATION

- Enter the name and contact details of the member’s primary care provider to ensure coordination of care.

4. ELIGIBILITY SCREENING FORM

- Under Diagnosis Criteria, specify all applicable diagnoses.
- Under Quality-of-Life Impairment, indicate if the member's serious illness has had an impact to their quality of life. If yes, specify all applicable quality of life impairments.
- In the Greatest Need section, provide a concise synopsis explaining why palliative care would be beneficial for the member. Be as specific as possible.

5. SUBMITTING THE COMPLETED FORM

- Send the completed form to the contracted palliative care provider or to the member's managed care plan care management team, as appropriate.
- If the member has administered their own screen or otherwise had the screen administered by a non-referring provider, member should contact their MCO (or, in case of FFS members, OMHC) to locate an in-network provider for assessment. If a member contacts a provider entity unilaterally without prior MCO engagement, they are encouraged to present their screen before assessment begins.

Best Practices:

- Complete all fields legibly and thoroughly
- Verify that the member (or their POA) is aware of and consents to this referral
- Attach any relevant clinical notes or supporting documentation
- Ensure timely submission to avoid care delays

If you have questions about form completion, contact Samantha.Lord@dhs.nj.gov

REFERRAL INFORMATION				
Referral Date:		Expected Discharge Date: (if applicable)		
Referring Person Title: <input type="checkbox"/> Care Manager <input type="checkbox"/> Provider <input type="checkbox"/> Self-referral <input type="checkbox"/> Other: _____				
Referring Person Name:				
Referring Person Email:		Referring Person Phone Number:		
Recommended Palliative Care Provider(s): (if applicable)				
MEMBER DEMOGRAPHICS				
Member Name: (last, first, mi)			Medicaid ID #:	
Health Plan:	<input type="checkbox"/> Aetna Medicare FIDE (HMO D-SNP) <input type="checkbox"/> Aetna Better Health of New Jersey <input type="checkbox"/> Fidelis Care <input type="checkbox"/> Horizon NJ Health <input type="checkbox"/> UnitedHealthcare (UHC) <input type="checkbox"/> Wellpoint		Gender: <input type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> Other	Age:
			DOB: (mm/dd/yyyy)	
Address:				
	street address	city	county	state zip code
Home Phone:			Cell Phone:	
Preferred Language:	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese-Mandarin <input type="checkbox"/> Chinese-Cantonese <input type="checkbox"/> Portuguese <input type="checkbox"/> Tagalog <input type="checkbox"/> Korean <input type="checkbox"/> Other: _____			
Member Consent (if applicable):	<input type="checkbox"/> Yes <input type="checkbox"/> No		Healthcare Power of Attorney (POA)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Caregiver/Alternate Contact Information				
If no Caregiver, enter 'None'; if Healthcare POA is Yes, enter Medical Decision Maker information				
Name:			Relationship:	
Email Address:			Cell Phone Number:	
PRIMARY CARE PHYSICIAN INFORMATION				
Name:				
Address:				
	street address	city	state	zip code
Office Phone Number:			Fax Number:	

ELIGIBILITY SCREENING FORM

Section 1

Does the member have any serious diseases? (select all that apply)	<input type="checkbox"/> Cancer (Stage III or IV)	<input type="checkbox"/> Chronic Obstructive Pulmonary Disease
	<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Other <i>(please describe)</i> :
	<input type="checkbox"/> Alzheimer’s and dementias	
	<input type="checkbox"/> Chronic Kidney Disease	<input type="checkbox"/> No – member has no serious disease

ICD-10 Code: (if known/applicable)	ICD-10 Code Description: (if known/applicable)
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Section 2

Is serious disease impairing the member’s quality of life? (select all impairments)	<input type="checkbox"/> Difficulty completing daily activities without assistance (e.g., bathing, dressing, using the bathroom, moving around, eating)	<input type="checkbox"/> Hospitalizations
	<input type="checkbox"/> Emergency room visits	<input type="checkbox"/> Other <i>(please describe)</i> :
		<input type="checkbox"/> No – no impairment

Section 3

Specify the greatest need of the member and/or caregiver that prompted this screening to be performed and provide a brief synopsis of this request:	
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SUBMITTING THE COMPLETED FORM

If the member answers anything other than ‘No’ in **Section 1** AND in **Section 2**, they may qualify for Community Based Palliative Care. **Send this screening form to the member’s healthcare provider or health plan to help the member access this benefit.**